DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING _____ B. WING _____	C 01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN 46805

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F 000	INITIAL COMMENTS This visit was for the investigation of Complaint IN00084841. Complaint IN00084841 - Substantiated. Federal/State deficiencies related to the allegations are cited at F272 and F314. Survey dates: January 21, 24, 25, 2011 Facility number: 000167 Provider number: 155266 AIM number: 100273740 Survey team: Ann Armey, RN TC Ellen Ruppel, RN app 2/17/11 BM Census bed type: SNF/NF: 69 Total: 69 Census payor type: Medicare: 9 Medicaid: 56 Other: 4 Total: 69 Sample: 4 These deficiencies also reflect state findings in accordance with 410 IAC 16.2.	F 000	RECEIVED FEB 15 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
F 272 SS=D	Quality review 1/27/11 by Suzanne Williams, RN 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 2/10/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assess a resident's pain before the administration of PRN (as needed) pain medication and failed to assess the effectiveness of the pain medication after it was administered. This deficiency affected 2 of 3 residents receiving PRN pain medication in a sample of 4. (Resident #B and #C)	F 272	**This Plan of Correction is the center's credible allegation of comliance.** Preparation and/pr execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed because it is required by the provisions of federal and state law. **F272 Comprehensive Assessments** 1. Residents affected by the alleged deficient practice; • Resident #B and #C have both had as needed pain medication discontinued and routine pain medication scheduled. 2. In House residents that could be affected by the alleged deficient practice; • An audit of in house resident PRN Medication Administration Records by the Director of Nursing have been audited and pain medication flow sheets have been implemented. 3. Systems to ensure alleged deficient practice does not recur; • The form: Pain Flow Sheet (LCAA-525) will be documented by the licensed nurse every time a resident receives as needed pain medication.	

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F 272	Continued From page 2 Findings include: 1. The clinical record of Resident #B was reviewed on 1/21/11 at 1:00 p.m. and indicated the resident was admitted to the facility on 11/27/10 with diagnoses which included, but were not limited to, right above the knee amputation and insulin dependent diabetes mellitus. The resident's care plan for pain, dated 12/30/10, indicated Resident #B had a history of chronic pain, a recent above the knee amputation and a contracture of the left foot. The interventions to address the pain, included but were not limited to, the following: *Monitor pain intensity following medication or treatment. *Observe behaviors that may indicate pain or increased pain, and *Evaluate the benefit of non-medical interventions. The January 2011 medication administration record indicated Resident #B had a physician's order to receive the pain medication, Hydrocodone-APAP 10/325 mg every four hours as needed for pain. The Controlled Substance Record indicated Resident #B received the Hydrocodone-APAP pain medication thirty times between 1/12/11 and 1/19/11. Resident B's Pain Flow Sheet indicated "Record the following data when implementing an intervention for pain," including: The location of the pain, the type of pain,	F 272	• Staff Development Coordinator will in-service licensed nursing associates on the use of the form: Pain Flow Sheet (LCAA-525). • SDC &/0r nursing admin will educate licensed nurses on the PRN pain flow sheet during orientation and as indicated for compliance ongoing. • Nursing admin will review Pain Flow Sheets monthly to ensure residents are receiving effective pain management and Pain Flow Sheets are being completed appropriately. 4. Monitoring to ensure alleged deficient practice does not recur; • Health Information Manager will audit all Medication Administration Record Books with monthly Medication Administration Record change out to assure new Pain Flow Sheets are placed in the Medication Administration Record. Residents that are started on as needed medications within the month will be identified in change of condition and DON or designee will assure a Pain Flow Sheet is implemented.	

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F 272	Continued From page 3 current intensity, precipitating factors, non-med interventions, medication/dose, the intensity of the pain after intervention and side effects. The Pain Flow Sheet for Resident #B was blank. There was no documentation, including in the nursing notes or on the medication administration record between 1/12/11 and 1/19/11, indicating the resident's pain was comprehensively assessed before and after each administration of the PRN pain medication. On 1/24/11 at 1:30 p.m., the DON (Director of Nursing) indicated each time the pain medication was administered the resident's pain should have been assessed and the information documented on the Pain Flow Sheet. The Pain Management Protocol, dated 3/2007, provided by the Administrator, was reviewed on 1/24/11 at 2:00 p.m. and indicated "...4. Nursing staff will monitor and document the effectiveness of the pain management program in the resident medical record (Nurses Notes/Pain Management Flow Sheet, Medication Administration record),... 5. Each resident who has been identified to have pain will have their pain assessed at least once per shift to include vital signs. Documentation of this assessment and vital signs will be placed on the Pain Flow Sheet...." 2. The clinical record of Resident C was reviewed, on 1/25/11 at 10:30 a.m., and indicated the resident had been readmitted to the facility on 1/7/11, following treatment for a septic right knee prosthesis.	F 272	Twice weekly a 100% audit of resident records for residents receiving as needed pain medications will be reviewed to assure Pain Flow Sheets are being utilized correctly. DON & or nursing admin will review audits and provide further education as needed.. • Audits will be brought to the Performance Improvement Committee with tracking and trending discussed. A goal of 100% compliance x 90 days with completing Pain Flow Sheets. • Plan to be updated as indicated by the PI committee 5. Date of Completion: 02/28/2011	

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F 272	Continued From page 4 Review of the controlled substance record for 1/22/11 to 1/24/11, indicated 12 tablets of oxycodone-apap 5-325 mg (a narcotic pain medication) had been administered to the resident. Review of the Medication Administration Record (MAR) and pain flow sheet records for the same period of time, indicated no entries of the medication being given or the severity, location or result of the effect on the pain being treated. Corresponding nurses' notes indicated "medicated for pain" on five of the 12 times the medication was given. No documentation of the effectiveness of the medication was recorded in the nurses notes. The pain flow sheet indicated the date/time, location, type, intensity, aggravating factors, non-medical interventions, specific medication with route of administration, initials of person giving the medication, intensity following 15 minutes, 30 minutes, 1 hour, and 3 hours plus side effects were to be recorded. The sheet was blank. This federal tag relates to complaint IN00084841.	F 272		
F 314 SS=G	3.1-31(a) 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314	**F314 Treatment/Services to Prevent/Heal Pressure Sores** 1. Residents affected by the alleged deficient practice; • The physician, registered dietician and wound nurse were notified for resident D & E and orders received from physician and plan of care updated as indicated. 2. In House residents that could be affected by the alleged deficient practice;	

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F 314	Continued From page 5 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: 2. The clinical record of Resident #E was reviewed on 1/24/11 at 2:00 p.m. and indicated the resident was readmitted to the facility from the hospital on 1/6/11. The hospital admission orders, dated 1/6/11, indicated "local care" to right foot and multiple "decubs" (decubitus ulcers). Nursing notes, dated 1/6/11 at 5:15 p.m., indicated the resident had three pressure areas as follows: on the right buttocks measuring 2 cm by 2 cm, on the thigh under the right buttocks measuring 4 cm by 4 cm and on the right heel. The note indicated "R (right) heal (sic) has open area .5 x 2 cm in size 0 (zero) drainage noted, 0 (zero) odor." A treatment order, dated 1/6/11, was obtained for Calmoseptine to the buttocks every shift and after incontinent episodes as needed. There was no documentation on the January 2011, TAR (Treatment Administration Record) indicating Resident #E received a treatment for the pressure area on the right heel until 1/11/11 (five days after the resident's return from the hospital). On 1/11/11, a physician's order for treatments to the pressure areas on the right heel was	F 314	• An audit of In House residents who are identified as at risk on the Braden scale (score < 14) will be conducted by nursing management to assure any pressure wound is identified, treatment in place, wound nurse notified and documentation is completed for pressure wound management by the wound nurse or nursing admin. • SDC and/.or nursing admin will educate nursing staff on communication of the onset or worsening of a pressure ulcer to the wound nurse, documented in 24hr report and orders received for treatment within 24hrs. • Nursing assistants will be inserviced by SDC and/or nursing admin regarding the reporting of any new wound identified to the charge nurse immediately; this will be completed ongoing for orientation and as indicated for compliance ongoing.	

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F 314	Continued From page 6 obtained, and indicated; "Xenaderm to rt. (right) heel daily cover w (with)/ gauze choice." On 1/24/11 at 2:30 p.m., Resident #E was observed in bed. A specialized bariatric mattress was on the bed. The resident's skin was checked by the DON (Director of Nursing). The resident had a dime sized, pink, superficial open area on the right heel. Resident #E had no open areas on the buttock or upper thigh. On 1/24/11 at 2:45 p.m., the ADON, who was the wound nurse, was queried about the delay in the treatment for the pressure area on Resident #E's right heel. The ADON indicated she thought xenaderm treatments had started when the resident was readmitted from the hospital. She was unsure why no treatment order was obtained and why a treatment was not started when the resident returned. This federal tag relates to Complaint IN00084841. 3.1-40(a)(2) Based on observation, interviews and record review, the facility failed to assess, immediately obtain treatment orders and implement interventions to prevent the reoccurrence of skin breakdown for 2 of 2 residents in a sample of 4 with pressure areas. This resulted in 1 of the 2 residents (Resident D) developing a black, unstageable area on the right heel. Residents D and E. Findings include:	F 314	3. Systems to ensure alleged deficient practice does not recur; • Licensed nurses will notify the DON of every new open area to assure proper notification of the physician and to assure the resident receives timely treatment. • Staff Development Coordinator will in-service all licensed nursing associates on the need to notify the DON and/or nursing admin of all open areas as soon as they are identified during orientation and as indicated for compliance ongoing 4. Monitoring to ensure alleged deficient practice does not recur; • The DON & or nursing admin will instruct licensed nurses when notified of open areas of notifying the physician of the open	

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F 314	Continued From page 7 1. During the observation of skin areas on Resident D, on 1/24/11 at 11:00 a.m., with the Assistant Director of Nursing (ADON), an area on Resident D's coccyx was observed to be healing and only having a small open area. The ADON was queried about the condition of the resident's feet and the resident's socks were removed for visualization of both heels. The right heel was observed to have a 50 cent sized black area after a dressing dated 1/23/11, was removed by the ADON. The ADON indicated she was the facility wound nurse and had not been notified about the area on the resident's heel. She indicated the resident had returned from the psychiatric unit at the local hospital in November, as a hospice patient. The ADON indicated the resident had returned with areas on the coccyx and the heel, but the heel area had been healed in December, 2010. She was unsure when the current area had developed or what treatment was being used. She also indicated the present pressure area was in the same place as the earlier one on the right heel. She indicated the resident had been on hospice care, but had improved enough so hospice was discontinued in December of 2010. The ADON indicated the specialty mattress which had been supplied by hospice was removed and a regular facility mattress was placed on Resident D's bed after hospice was discontinued. During an interview with Resident D, on 1/24/11 at 11:00 a.m., while the observation of the heel was taking place, she indicated her shoes were tight and she thought the right heel area was caused by the shoe. The shoes were observed beside her bed and were diabetic shoes which the resident indicated the therapy department had helped her obtain.	F 314	area and obtaining a treatment order. The DON will then follow up to assure the wound nurse and Registered Dietician are notified of the need for assessment and follow up. • Audits will be conducted on in house residents with pressure ulcers 2x/wk x30 days then weekly x30 days then monthly ongoing by the DON and/or nursing admin; in addition plan of care updated and treatment orders received and current • Plan to be updated as indicated by the PI committee 5. Date of Completion: 02/28/2011	

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F 314	Continued From page 8 The clinical record of Resident D was reviewed, on 1/24/11 at 1:30 p.m., and indicated the resident had returned from the local psychiatric hospital unit on 11/22/10, with diagnoses including, but not limited to: bi polar disorder, acute renal disease, congestive heart disease, left leg deep vein thrombosis and insulin dependent diabetes. She was on hospice care at the time of readmission. Hospital doppler studies, dated 11/16/10, indicated the resident had extensive deep vein thrombosis in the left lower extremity and no evidence of deep vein thrombosis in the right lower extremity. A prealbumin level, dated 12/23/10, indicated the resident's prealbumin was 20.2 (normal limits being within 18.0 - 35.7). Hospice records indicated the hospice had been discontinued on December 21, 2010, due to the resident's improvement. The hospice clinical note, of 12/14/10, indicated she had a healed pressure area on the right heel and an area on the coccyx which had diminished in size to a stage II area. Facility skin sheets, dated 12/7/10, indicated the previous area on the right heel was healed on 12/7/10. Braden Pressure Sore Risk assessments, dated 11/22/10 and 1/3/11, indicated the resident was at risk for skin breakdown due to friction and shear, limited mobility, being bedfast or chairfast, occasionally moist and limited in sensory perception. The care plan, dated 12/30/10, related to skin breakdown indicated the resident was at risk due to a stage 4 area on the coccyx. The approaches included, but were not limited to: "Needs wound	F 314		

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F 314	Continued From page 9 care as ordered by physician. Offer supplemental nutritional support to resident (multi-vitamin). Needs a daily observation of skin with routine care. Needs full skin evaluation weekly with bath/shower. Use pillows or other supportive/protective devices to assist in positioning. Avoid restrictive clothing. Monitor for changes in skin status that may indicate worsening of pressure ulcer and notify the physician." Weekly skin integrity sheets indicated Licensed Practical Nurse (LPN) #20 had first noticed the area on Resident D's heels on 1/3/11, and wrote "mushy heels-fluid filled areas to bilat. (bilateral) heels. Heels floated." There was no documentation to indicate she had notified the physician, dietician or wound nurse of the areas. The skin sheet, dated 1/10/11, completed by the same nurse, indicated the heels were "mushy" and on the 1/17/11 entry, she had written "dried blister." The Medication Administration Record (MAR) for January of 2011 indicated Betadine pads were being applied to the right heel and covered with border gauze. The date the Betadine was started was 1/15/11. No order for the Betadine could be found on 1/24/11. LPN #20 was interviewed, on 1/24/11 at 3:15 p.m., and when queried about notifying the physician, wound nurse and dietician, she was unsure if/when she had notified them. She obtained an order for the Betadine on 1/24/11, nine days after starting the treatment. The facility dietician was interviewed, on 1/24/11 at 2:20 p.m., and indicated she was recommending a multivitamin being restarted and Prostat 30 cc (a nutritional supplement) twice	F 314		

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F 314	Continued From page 10 daily. She indicated the resident had been on multivitamins prior to hospice, but the vitamin had been discontinued when hospice started. The 10/7/10 facility policy regarding pressure areas was provided by the Assistant Director of Nursing, on 1/24/11 at 3:00 p.m., and it indicated, in part, "The facility's procedures are such that all disciplines are alerted immediately if the resident either has skin breakdown or is at risk for the development of skin breakdown." Resident D was observed, on 1/24/11 at 1:30 p.m., in the lounge area, wearing the shoes she had earlier indicated "hurt" her foot. When queried about wearing the shoes, she indicated the staff had put the shoes on her. The most recent Minimum Data Set (MDS) assessment, of 1/3/11, reviewed on 1/24/11 at 1:45 p.m., indicated she needed help with dressing and transfers. The ADON measured the area on the right heel and provided the measurement on 1/25/11 at 8:45 a.m.. The black area on the right heel was 3.5 cm (centimeters) by 0.4 cm with no depth and was unstageable.	F 314		